

Davis Sound Mind

SPORTS PERFORMANCE PSYCHOLOGY ATHLETE INFORMATION

First Name: _____ **MI** _____ **Last :** _____

Address: _____ **City:** _____ **St.** _____ **Zip** _____

Birth Date: ____/____/____ **Age:** _____

Education Level: _____ **Email:** _____

Home Phone: _____ **Wk Phone:** _____ **Cell:** _____

Marital Status: Single Married Divorced

Employment Status: Full Time Part Time Full Time Student Part-Time Student

RESPONSIBLE PARTY (if other than patient):

Name: _____ **Address:** _____

City: _____ **St.** _____ **Zip** _____

Home Phone: _____ **Work Phone:** _____ **Cell** _____

In emergency, contact: _____ **Phone #:** _____

State the problem or concern for which you are seeking treatment:

What have you done to try to solve this problem?

What changes are you seeking?

Previous Sports Therapists? _____ **When?** _____ **Was it helpful?** _____

Are there current suicidal thoughts? _____ **Have you attempted Suicide?** _____

Have you had difficulty with anger? _____ **Been violent?** _____ **Injured someone?** _____

Have you ever had work, relationship, health, or legal problems due to your use of alcohol or drugs? _____

Date you last drank alcohol _____ **How much typically?** _____ **How often?** _____

What do you drink _____

Do you use tobacco/Nicotine? _____ **How much?** _____ **How often** _____

Do you use Marijuana? _____ **How much?** _____ **How often** _____

Date you last used drug(s) and type of drug used: _____

Previous drug use and what kind? Teens _____ 20's _____ 30's _____

How much coffee, colas, or teas do you drink per day? _____

Family history of mental health or substance abuse problems? _____

Check any that have happened: Emotional Abuse Physical Abuse Sexual Abuse

Have you had a head injury with loss of consciousness or caused you to see a doctor?

Have you had any of the following:

Learning disabilities Hyperactivity Disciplinary problems

Menstrual problems Possible PMS Premenopausal/Menopausal

Any type of sleep problems: Falling asleep Staying asleep Early awakening Difficulty awakening

Any appetite changes Weight changes Current weight: _____ lbs. Height: _____

Describe your worst nutritional habits _____

Legal Problems? Arrests? _____

Exercise? Frequency of physical activity? _____

Hobbies / Interests? _____

Describe your religious or spiritual beliefs _____

Check any of the following concerns - Make any additional comments

Shyness	Panic	Attention Deficit	Anxiety
Health	Controlling	Guilt	Relaxation
Inferiority	Depression	Over-Weight	Compulsions
Self-Injury	Concentration	Disorder Finances	Phobias
Memory Problems	Self-Esteem	Spending	Fears
Ambition	Confusion	Alcohol	Worry
Work	Perfectionism	Drug Use	Stress
Anger	Relationship	Low Energy	Obsessions
Jealousy	Mood Swings	Gambling	Insecurity
Nervousness	Career	Self Critical	Parenting
Making Decisions	Physical Pain	Sexual Problems	Critical

Comments:

Describe your health at present

List any medical problems you have

List any operations you have had

List any allergies you have, including allergies to medications

List any recently discontinued medications, psychiatric medications

List medications you are taking	Dosage	Number of times per day	Prescribed since when

May we inform your coach of evaluation results?

Coaches Name: _____ Address: _____

Ph.: _____ Fax: _____ (Complete address is needed)

(Please fill out next page)

Sports Motivational Scales

Select the number on the scale for each

Very little → Very much

Negative Self Talk

Sometimes doubt myself

Think my effort will go poorly

Reflect on past mistake or poor performance

Question if praise is real

Anger occurs during performance

Anger occurs during practice

Anger has resulted in officials warning or penalizing

Anger occurs in my personal time

Parent stress bothers me

Coach stress bothers me

Teammate stress bothers me

Competitor taunting bothers me

Cope with expectations bothers me

Use imagery effectively

Family, work, personal relationships create distractions

Sometimes i am distracted during training or competing

Consistency of my effort varies

Pre-performance anxiety is present

While performing I get anxious

Level of comfort as a leader

I find myself involved in conflicts with team members

Negative feelings about others on the team

AUTHORIZATION FOR SPORTS PSYCHOLOGY SERVICES

I, _____ (Athlete or Parent/Representative), authorize and consent to the evaluation and consultation to the athlete named above. I understand that payment is required at time of service, and take full responsibility for all fees resulting from services. I am aware that I am ultimately responsible for fees incurred as a result of services rendered. I also accept financial responsibility as outlined below, even though that may be discrepant from the policies of my insurance carrier.

I authorize Davis Sound Mind to utilize my debit / credit card to process my copayment at the time of service, process my deductible, and process my late cancellation, missed appointment.

Appointment Cancellation Policy: Please call twenty-four hours before, or by 3pm the day prior to cancel your appointment. Workplace/School demands that you cancel your medical appointments are not acceptable.
Late Cancellation: \$110.00 Less than 24 hours cancellation. This will be processed on you card on file within five days.
Missed Appointments: \$110.00 will be charged for a missed appointment. This will be processed on you card on file within five days.
Returned Checks: \$35.00 fee for returned checks.

SIGNATURE

DATE

Legally Authorized Representative Signature

DATE

Davis Sound Mind

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Sports Psychology Services

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NEW ATHLETE INFORMATION

As a new client in our practice we hope that you find the relief and answers that you have come to discuss. This is a commitment on your part and our part to resolve problems and to begin engagement in solutions to your concerns. We will use years of experience and expertise for your benefit. Rest assured that when your appointment time is here, we will be here for you. Bring in all assignments, questions, and notes when arriving. Reviewing your progress this way will help us most successfully determine your next step. It is likely that we will be utilizing various techniques. We count on your involvement as this often has a major impact on the pace of progress.

***Journaling** is very helpful regarding tracking the changes you are looking to make. When opportunities are present for change please write an analysis of how well you handled the new change in your behavior.*

***Positive Attitude** is the active use of positive comments that you make aloud to others and about yourself. Achieving these positive comments while reducing negative comments to a zero will help you feel better.*

***Health** Resolve to engage in healthy lifestyle.*

Appointment & Cancellation Policy:

Appointments: Sessions by appointment only. \$120.00 Initial Consultation. \$110.00 Returning appointments.

Appointment Cancellation Policy: Please call twenty-four hours before, or by 3pm the day prior to cancel your appointment. Workplace/School demands that you cancel your medical appointments are not an acceptable waiver.

Late Cancellation: \$70.00 fee for cancellation the day of your appointment. This will be processed on your card on file.

Missed Appointments: \$70.00 will be charged for a missed appointment. This will be processed on your card on file.

Returned Checks: \$35.00 fee for returned checks.

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